Homosexual Transmission of Infectious Syphilis

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• **Homosexuality is more prevalent in our society than many suspect.**

The incidence of infectious syphilis is increasing and the homosexual is playing an increasing role in its epidemiology.

Fifteen per cent to 70 per cent of homosexuals practice analism.

The diagnosis of venereal disease should always be kept in mind when dealing with anorectal problems.

BECAUSE THE SUBJECT is usually not discussed in medical journals other than those of psychiatry and psychoanalysis, the profession at large is often ignorant of the incidence of homosexuality and its relationship to venereal disease.

Brown[2] recently said that since 1957 infectious syphilis has been increasing at an alarming rate in all races, sexes, ages, social groups and geographical areas. Table 1 shows the increase in the incidence of syphilis in five metropolitan West coast areas between 1955 and 1959. It is the opinion of Tarr and Lugar,[9] that the increase in the Los Angeles area is due to homosexual transmission. Others also have expressed belief that the increase in infectious syphilis is ascribable to homosexual contact.[11] If 37 per cent of the male population have some homosexual experience between adolescence and old age,[5] these facts may be readily explained.

In Tarr and Lugar's[9] private series of 194 patients diagnosed as having infectious syphilis, 170 (87.6 per cent) were males. Eleven were unable to identify a contact; but of 159 supplying adequate information, 89 (56 per cent) had male contacts only and 21 (13 per cent) had both male and female contacts. The 170 men patients had had 551 male contacts. In the investigation of this latter group, 93 were found to have syphilis. Stewart[8] told of a recent case of secondary syphilis in a passive homosexual. Treating the disease in this case offered no particular problem, but the epidemiological problem we face today in dealing with infectious syphilis was indicated in the fact that the patient had 14 current sexual contacts.

At the Division of Venereal Disease Control for the Province of British Columbia, there were 24 cases of infectious syphilis in 1961. Fifteen of the patients were homosexuals. A history of 54 contacts was elicited from this series and 32 of the contacts were located. Nine of them had early syphilis. Two had been treated for syphilis on a previous occasion. From 1957 to 1961, inclusive, there were 139 cases of syphilis at the Division of Venereal Disease Control, and in 130 of them the disease was transmitted by a homosexual. Not until 1961, the last year of the period, did cases in females begin to appear. It is assumed that since most homosexuals are gainfully employed, the data of private physicians were of a similar cast.

These statistics should make private physicians more aware of syphilis when considering any lesion about the mouth or anus. Although some investigators have reported the incidence of analism to be 15 per cent to 20 per cent among homosexual men,[1,12] it was found to be 70 per cent among 650 who were interviewed at the Division of Venereal Disease Control for B. C.[7]

Lest the physician's diagnostic suspicion be led astray when he is confronted with lesions about the anus, it should be emphasized that not all homosexuals have effeminate mannerisms. On the contrary—a homosexual may be of the most masculine demeanor and may even marry to supply the guise of conformity.

A factor in the transmission of syphilis is promiscuity, which Trice[10] noted is far greater in homosexual than in heterosexual men.

Two recent cases observed in private proctologic practice in a period of three months are worthy of note.

Submitted October 15, 1962.

TABLE 1.—*Number of Cases of Primary and Secondary Syphilis by Year in Five West Coast Metropolitan Areas (1955-1959)*

City	1955	1956	1957	1958	1959	Per Cent Change 1955-59
Los Angeles City	70	58	113	223	274	+291.4
San Francisco	45	89	124	144	311	+591.4
Portland	26	11	10	6	9	− 65.4
Seattle	15	18	13	14	36	+140.0
Los Angeles County excluding Los Angeles City	27	39	33	51	57	+111.1

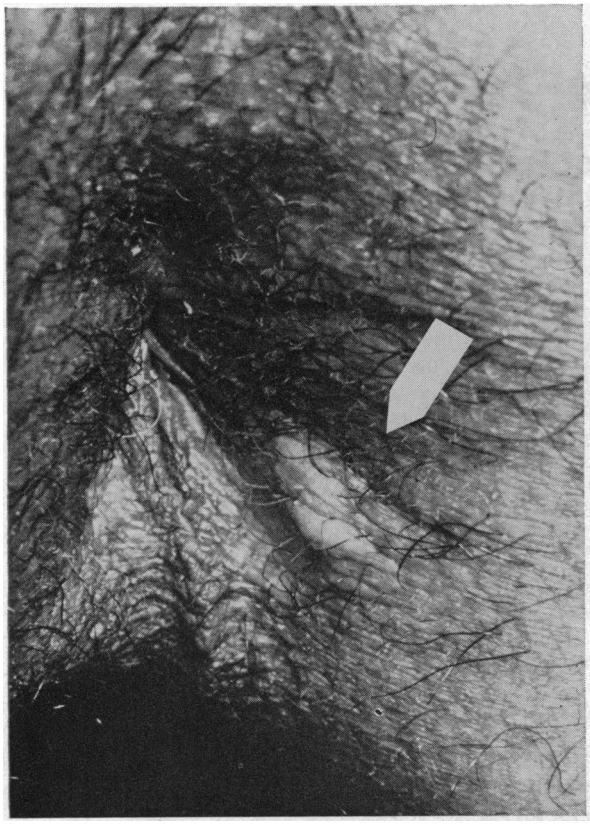

Figure 1.—(Case 1) Chancre on right anterior phase of anus, after five days of penicillin therapy. It appeared pearly white at this stage.

CASE 1. A 35-year-old single white clerk had been treated previously by the author for venereal warts. A culture of material swabbed from the rectum was negative for gonococci. The patient returned later with complaint of a "sore" on the anus which was aggravated by underclothing. Upon examination a necrotic ulcer 1 cm in diameter was noted at the anal verge in the left phase (Figure 1). It had a grey base and a pink areola. It was not similar to fissure, to a malignant lesion or to the excoriation sometimes seen in acute pruritus ani. A dark field examination was positive for syphilis, as was a serologic test of the blood. The patient admitted being a passive homosexual and further questioning elicited that he was very promiscuous.

CASE 2. A 17-year-old Indian boy complained of "a sore" near the anus. A small grey ulcer with pink areola was present on the right anal verge (Figure 2). Dark field examination and a serologic test of the blood were positive for syphilis. A culture of material from the anus was negative for gonococci. The boy gave a history of having had sexual relations with a well-dressed man who had picked him up in a late model car and paid him for his services.

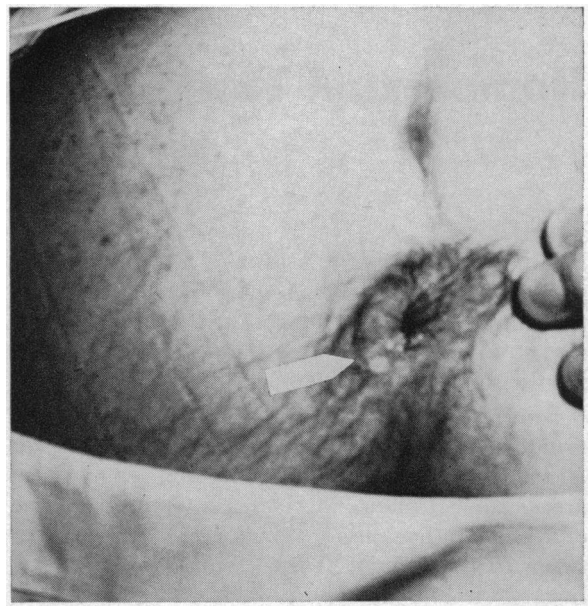

Figure 2.—(Case 2) Primary chancre before treatment

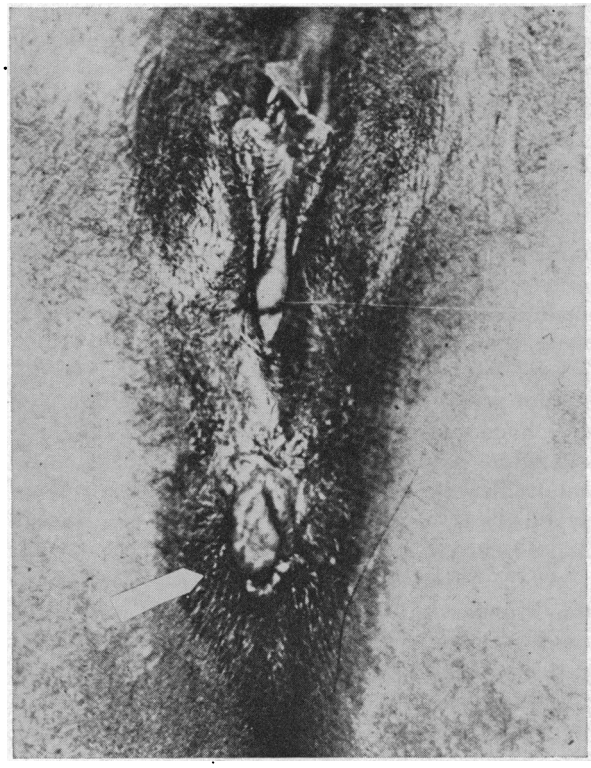

Figure 3.—An initial lesion on a hemorrhoid, which could be mistaken for a chronic fissure.

Three months later he was admitted to Oakalla Prison, where he was found to be reinfected with syphilis.

Jackman,[3] noting that syphilis of the rectum and anus is seldom reported clinically, expressed belief

that the infrequency is due to: (1) Self-treatment by patients who believe their problems to be hemorhoids. (2) Failure of the physician to consider syphilis as a diagnosis along with other rectal conditions. (3) The patient's withholding of information for fear of being discovered as a sex deviate. (4) Failure of the physician to consider the anus and rectum as a primary site when confronted with a serologic reaction positive for syphilis. The lesions in the two cases herein reported took the form of small ulcers, but chancres located as they are near the anus, may become so modified as to resemble dermatitis or a chronic fissure.[4] A hard chancre on a hemorrhoid, such as was reported by Porter,[6] could be mistaken for a chronic fissure (Figure 3). When confronted with any suspicious lesions about the anorectum, I feel a dark field and blood serologic test for syphilis should be included in any diagnostic tests.

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